851 Corporate Dr., Ste. 201 Ph: (859) 429-0718

Lexington, KY 40503-5429 Fax: (418) 431-0407

# Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 

**CLIENT REFERRAL FORM**

**PATIENT DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*First Middle Last*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: □Full-Time □Part Time □Disability □Unemployed

Age: \_\_\_\_\_ School: Grade: \_\_\_\_\_\_

Telephone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave Messages: □YES □NO ( ) \_\_\_\_\_\_\_\_\_\_ Leave Messages: □YES □NO

Home Cell

Marital Status: □ Married □Single □Divorced □Separated □Widowed □Significant Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse/Other if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:(\_ \_ ),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave Message?: □ YES □NO

## INSURANCE INFORMATION:

1. Type of Insurance: □No Insurance/Private Pay □Major Medical □Medicare □ (MA) Medicaid, □EAP □Other

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy/Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Card Holder's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_S.S.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to primary cardholder: □Self □Spouse □Child □Other

1. Type of Insurance: □No Insurance/Private Pay □Major Medical Medicare □ (MA) Medicaid, ·□ EAP □Other Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy/Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#:\_\_\_\_\_\_

Primary Card Holder's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_S.S.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to primary cardholder: □Self □Spouse □Child □Other

## REFERRAL SOURCE:

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility/Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL**

**Service(s) Requesting:** □Individual Therapy □ Medication Management Evaluation □O t h e r

Discuss your concerns in this space: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Continue on back if needed--+

**Previous behavioral/mental health treatment?** □Yes □No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the diagnosis/out come? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-I-For Office Use Only-I-**

First Appointment Date/Time: Letter sent to referral source/date: \_\_\_\_\_\_\_\_

*Update February 2020*